Good morning. My name is Reena Kapoor, and I am testifying today in support of **SB 1059**, An Act Concerning the Correction Accountability Commission, the Office of the Correction Ombuds, the Use of Isolated Confinement, Seclusion and Restraints, Social Contacts for Incarcerated Persons, and Training and Workers’ Compensation Benefits for Correction Officers.

I am a forensic psychiatrist and Associate Professor at the Yale School of Medicine. I have spent my career providing mental health care to people involved with the criminal-legal system, including in the Connecticut Department of Correction. My scholarly work focuses, in part, on studying the psychological effects of solitary confinement. Over the past ten years, I have advised the U.S. Department of Justice, National Institute of Justice, state legislatures, federal courts, prison systems, and advocacy groups about mental health treatment and the use of solitary confinement in prisons. It is my privilege to speak with you today about these critically important subjects.

The bill before us is complicated, but it has one over-arching goal: to end the antiquated practice of locking prisoners in tiny rooms for weeks and months on end, instead requiring the prison system to provide them with modern, high-quality mental healthcare that more closely resembles treatment in the community.

This change is long overdue, as scientific studies have clearly demonstrated **several important facts about solitary confinement:**

1) **Solitary confinement does not accomplish its intended objective of reforming prisoners’ behavior for the better.** When you compare prisoners’ institutional misconduct before and after being locked in solitary confinement, there is no difference at all in the frequency or severity of misconduct. This means that solitary confinement simply does not work as a way to “teach people a lesson.”

2) **Solitary confinement disproportionately affects the most vulnerable prisoners:** very young people, people of color, people with serious mental illnesses, people with intellectual disabilities, and people who have been traumatized. Approximately 30% of prisoners in solitary confinement have a diagnosed mental illness, which is roughly twice the rate in the general prison population.

3) **Solitary confinement prevents prisoners from accessing mental healthcare that they need just as much as someone with diabetes needs insulin or a person with asthma needs an inhaler.** The American Psychiatric Association recommends that prisoners in solitary confinement receive at least 10 hours per week of structured treatment activity out of their cells – a recommendation that is largely ignored by prison systems.
4) Solitary confinement can cause lasting emotional damage, both during the confinement and even years after release. Suicide rates are seven times higher in solitary confinement than in the general prison population, and the risk of suicide remains elevated after release. Similarly, individuals who have spent time in solitary confinement are at increased risk of death in the year after they return to the community, showing that the harms of such confinement are not cured simply by unlocking the cell door.

If you consider all of these factors together, you can only conclude that we need alternate ways of treating people in prison – ones that are more humane and effective. SB 1059 is an important step in that direction, creating limits on who can be placed in solitary confinement and for how long, as well as directing prison systems to find creative alternatives to keep incarcerated people safe and healthy.

I would note that the changes outlined in SB 1059 are just as important for the staff in correctional facilities as they are for the prisoners. As anyone who has worked in a prison can tell you, the restrictive conditions of solitary confinement units heighten tensions between correctional officers and prisoners, leading to highly regressed behavior on both sides: name-calling, taunting, threats, and worse. This is not a critique of correctional officers’ professionalism; it is simply an acknowledgement that they are human beings who sometimes respond to stressful situations in less than ideal ways. If we want to break the cycle of burnout amongst correctional officers, high levels of staff turnover, and understaffing that leads to an even more stressful work environment, we simply must find alternatives to solitary confinement.

Lastly, I want to acknowledge Connecticut's efforts to reduce the use of solitary confinement in DOC over the past decade. SB 1059 builds upon DOC's accomplishments, ensuring that the effort to limit the use of solitary confinement remains a priority when the system is inevitably faced with budget cuts or leadership changes. In my experience as a prison psychiatrist and monitor of correctional mental health services around the country, legislation and external oversight are essential components of a long-term strategy to reduce the use of solitary confinement. Without them, even the most successful reforms can vanish with the change of a prison warden or Commissioner of Correction.

In conclusion, SB 1059 takes important steps to improve prisoners' mental health, and I urge the committee to support it. For too long, DOC has been left on its own to manage the serious problems that lead to and result from the use of solitary confinement. The current bill shifts that responsibility to all of Connecticut’s citizens, making us partners in improving the lives of incarcerated people and the staff who care for them.